Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Patrick J. Laurini, DC

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-0226-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 26, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Requestor did not include a position statement in the submitted documentation.

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 11/21/13. The requestor used the DRE method to determine the IR. The MAR for that is $150.00, which Texas Mutual paid.

No additional payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 21, 2013	Designated Doctor's Examination	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 (j) explains the procedures for billing and reimbursement of Designated Doctor Examinations.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1 – Workers Compensation State Fee Schedule Adjustment
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

Issues

1. What is the correct MAR for the service in question?

2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(3)(C), "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." Review of the documentation submitted finds that the Designated Doctor reported findings of Maximum Medical Improvement, as ordered by the Division. Therefore, the correct MAR for the examination to determine Maximum Medical Improvement is $350.00

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (ii) The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area."

   The narrative report included in the submitted documentation indicates that "Table 71 DRE Impairment Differentiators" was used in the determination of Impairment Rating. This table includes range of motion findings necessary to determine the correct DRE category for Impairment. The narrative also supports that a full physical examination with range of motion was performed. Therefore, the correct MAR for the examination to determine Impairment Rating is $300.00.

   The total MAR for this examination is $650.00.

2. Review of the submitted documentation finds that the requestor submitted a medical bill for $650.00. Review of the submitted documentation indicates that the insurance carrier reimbursed $500.00 on 12/26/13. The Division finds that the requestor is entitled to additional reimbursement of $150.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	December 23, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.